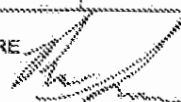


Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALF014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/24/2023
NAME OF PROVIDER OR SUPPLIER SPRING WIND ASSISTED LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1072 NORTH 22ND STREET LARAMIE, WY 82072		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	OPENING COMMENTS Rules and Regulations utilized for this survey are: Rules and Regulations for Program Administration of Assisted Living Facilities, Chapter 12, effective 08/24/2020. Rules and Regulations for Licensure of Assisted Living Facilities, Chapter 4, effective 06/28/2001. A complaint survey was conducted by Healthcare Licensing and Surveys on 8/24/23. The survey was prompted by complaint intake LIC-23-44. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint.	S 000			

Wyoming Dept of Health, Aging Division, Healthcare Licensing and Surveys
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director

(X6) DATE

9/8/23

STATE FORM

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F0TR11

If continuation sheet 1 of 1